STIcking Points

The Road Beyond Dean Street

Kees Rietmeijer
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Over a decade ago, Heijman and colleagues from the Amsterdam Health Department published an article in the journal *Sexually Transmitted Diseases* detailing the implementation and evaluation of a risk-based, short screening protocol for asymptomatic patients visiting their STD clinic. The short protocol included a minimal sexual and medical history followed by phlebotomy for HIV and syphilis testing and self-obtained urine or vaginal sampling for gonorrhea and chlamydia testing - without physical examination.[1]

In the Denver STD clinic, we had implemented a similar protocol we referred to as "Express Visits" in 2003 and published our results in *STD* in 2008. Our paper suggested that about a quarter of patients visiting the clinic could be safely tested using the express visit model, increasing clinic efficiency and reducing in-clinic patient time.[2]

Over time, many clinics in the U.S. and elsewhere have now estblished some form of express visit, or fast-tracking protocol and several more articles have since been published on this practice innovation. As we have discussed previously, the implementation of express visits has presented with some trade-offs, including potentially missed diagnoses of asymptomatic urethritis is men and vaginitis/vaginosis in women.[3] However, a recent detailed and well-designed study from the University of Washington confirmed the effectiveness and efficiency of this approach, while also showing that an express visit option could be implemented with minimal undesired consequences.[4] Furthermore, this study also found that express visits can be implemented using a simplified triage protocol.[5]

In the past few years, the express visit option has seen renewed attention with the opening and subsequent media coverage of Dean Street Express in London, where STI testing is available in a stand-alone clinic without any clinician interaction. In this country, the Centers for Disease Control and Prevention and the National Association of County and City Health Officials have recently partnered to develop a community of practice to explore STI express visit models that will ultimately lead to the implementation and evaluation of a small number of demonstration projects, as was discussed by the project's medical consultant, Dr. Hillary Reno, at the recent 2018 STD Prevention Conference.

These are encouraging developments that should lead to further discussion and consideration.

In this context, I think it is important to realize that the background against which the express visit system was developed at the Denver clinic was very different than how Dean Street Express came about. Express visits in Denver were conceived when a no-cost option was needed after the implementation of a mandatory co-pay in the clinic had resulted in a dramatic

loss of patient volume and diagnosed STIs.[6] Thus we were able to offer basic testing to clients who could not afford the co-pay. The costs of the express visit system were absorbed by the overall clinic budget. By contrast, Dean Street Express was established to accommodate Dean Street 56, a full-service HIV clinic that became overburdened by STI testing as a developing standard of care for otherwise asymptomatic patients in HIV care and PrEP clients. Cost was not a primary driver; in fact, the clinic was able to charge the U.K. National Health Service (NHS) for visits and even generated a profit after its first year of service. Unfortunately, as the NHS is facing significant financial cutbacks, funding for Dean Street Express has become uncertain and the clinic is now looking into alternative ways of providing services, including home-based testing.

So, where are we?

In my view, the express visit has now been established as an important option in STD clinical practice, with positive impact on both clinic efficiency and client satisfaction. The future of stand-alone express clinics is less certain. As the Dean Street Express experience shows, funding will be a critical issue. Clearly, as STIs continue to rise in this country, funding for STI services should be a public health priority. However, it is less clear if public health agencies in the most affected areas have the financial and political backing to meet these needs. Billing for services should obviously also be considered. However, many clients in need of these services reside in non-Medicaid expansion states, lack insurance coverage and will have limited means to cover out-of-pocket expenses. Another limitation of stand-alone express clinics is that these clinics will not only attract asymptomatic persons in need of regular STI screening, but also those who have symptoms or other needs that cannot be addressed during an express visit. Thus, at a minimum, express clinics should have the capability of referring patients to clinics where comprehensive STI services are available. Ideally, those services should be close by which begs the question why a stand-alone clinic will be necessary as it might better be conceived as an annex to existing clinics, which from an economical perspective would make the most sense.

In the meantime, it will be very interesting to see what the NACCHO/CDC initiative will come up with, and I for one, am very much looking forward to the outcomes of the project.

References

(direct links to the below references are embedded in the text above)

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